Columbus Recreation and Parks Department
Participant Waiver Form

I. PARTICIPANT INFORMATION

First Name: _____ Last Name:_____ Home Phone:_____
Address:_____ City:_____ Zip Code:_____
Circle One: M F Age:_____ Date of Birth:_____ Current Grade:_____
Mother/Guardian Name:_____ Work Phone:_____ Cell:_____
Father/Guardian Name:_____ Work Phone:_____ Cell:_____

II. EMERGENCY CONTACT INFORMATION

If parents or guardians are unable to be reached, contact:

Name: _____
Day Phone: _____
Relationship to Participant: _____

Name: _____
Day Phone: _____
Relationship to Participant: _____

III. MEDICAL INFORMATION

Physician and/or Clinic

Name:_____ Phone Number:_____

Dentist and/or Dental Clinic

Name:_____ Phone Number:_____

Please provide specific information for any **medical or behavioral** conditions in which staff should be aware in order to provide a safe and successful environment (allergies, activity restrictions, asthma, ADHD, etc.)

_____
_____
_____

Medication Policy: Columbus Recreation and Parks Department staff shall not administer medication to participants of their programs. All medication taken by participant shall be self-administered, and no participant on medication shall be registered in the program unless that person is capable of taking his/her own medications, or parent/guardian is available to administer the medication. Recreation staff may (1) Remind a participant to take medication (2) Assist participant by taking the medication from the locked storage area and hand it to the participant.

Please identify type, dosage, and time for all medication that the participant is currently taking.
Medication:_____ Dosage:_____Frequency:_____

IV. PARTICIPANT/PARENT/GUARDIAN RELEASE

_____ has my permission to participate in all activities offered during the camp. If attempts to contact me at the above listed phone numbers are unsuccessful. I authorize and give my consent for any emergency medical, surgical or dental treatment for my child (listed above) anywhere/anytime should it be deemed advisable by a qualified medical Doctor or Dentist, and the transportation of the child to the nearest hospital reasonably accessible. I understand this is to avoid undue delay and to assure prompt attention/treatment in an emergency. I hereby give permission to the City/CRPD to provide routine first aid care, administer prescribed medications in a life or death situation, and seek emergency medical treatment for my child when deemed necessary. In case of accident or injury I will not hold the City of Columbus or its employees responsible. I understand and assume all risks that may occur during my child's participation in these programs. I understand that should any injury occur to my child at this camp, I will be responsible for all medical treatment and other costs through my medical insurance policy and/or personal finances.

SIGNATURE: _____ DATE:_____
(parent or legal guardian)

Updated 5/2015